Attachmt. D3

OMA-3012 (07191)
PS-00249

CAP PLAN OF CARE

Initial ___ Revision___ CNR ____

Effective Date _____

Case Manager_____ __ Client _____

MID _____ _____

Cap Agency _____ Case ID _____ LOC _____

The Plan of Care is to document formal and informal services to be provided to the Client. It also is used to outline the goals and objectives for the Client and staff, and record the Client's acceptance of CAP as an alternative to institutional placement. The Plan must be revised as needed according to changes in the Client's situation. Each Plan and each revision must be approved according to CAP policies and procedures.

A, Goals and Objectives

Use this space to list goals; objectives related to accomplishing these goals; and any applicable target dates. Show the services and informal support used to meet each objective. Goals should involve such areas as maintaining/improving the Client's health, safety, and independence. Progress notes are optional.

1. GOAL: OBJECTIVES (AND TARGET DATES, IF APPLICABLE)	SERVICES / SUPPORT	COMMENTS / PROGRESS NOTES
2. GOAL: OBJECTIVES (AND TARGET DATES, IF APPLICABLE)	SERVICES / SUPPORT	COMMENTS/ PROGRESS NOTES
3. GOAL: OBJECTIVES (AND TARGET DATES, IF APPLICABLE)	SERVICES I SUPPORT	COMMENTS/ PROGRESS NOTES
4. GOAL: OBJECTIVES (AND TARGET DATES, IF APPLICABLE)	SERVICES / SUPPORT	COMMENTS/ PROGRESS NOTES

CAP PLAN OF CARE

CLIENT_____

B. COST SUMMARY
List all services to be provided. When payor is not Medicaid, enter one of the following codes in Column S:
I = Medicare 2=Title XX 3=Title 111 4 ~- Insurance 5=Local Funds 6=Voc. Rehab. 7=Family/Friends
8=Client (non-covered services only) 9= 10= 11
Medical Supplies must be itemized in Part C, with the total brought forward below.

SERVICE	CODE	PROVIDER AGENCY	FREQUENCY D - Days M = Mos. V - Visits H - Hours	FROMITO	UNIT RATE	AVERAGE MONTHLY COST MEDICAID	OTHER	S
Screening	W81 00		1 /yr.	N/A				
Case Management	W8102		H/M	N/A	/h			
Nursing Visits	550				/v			
*Medical Supplies	N/A	N/A	N/A	N/A	N/A			
MEDICAL SUPPLIES MUST BE ITEMIZED IN PART C.					TOTALS			

Attchmt. D3

CAP PLAN OF CARE

CLIENT _____

%I. %1WIJI - . -:--

Itemize medical supplies here and transfer the Total Average Monthly Cost to Part B. When the payor is not Medicaid, enter one of the following codes under Column S. I = Medicare 2=Title XX 3=Title III 4=Insurance 5=Local Funds 6=Voc. Rehab. 7=Family/Friends 8= Client (non-covered services only) 9= 10= 11 =

MEDICAL SUPPLIES	CODE	PROVIDER AGENCY	NUMBER OF UNITS PER MONTH	BILLING UNIT (case, bottle, etc.)	COST PER UNIT	AVERAGE MONTHLY COST		
						MEDICAID	OTHER	S
TRANSFER THESE TOTALS TO PART B					TOTALS			

Attachmt. D3

CAP PLAN OF CARE

CLIENT _____

D. INFORMAL SUPPORT

Include information about the support to be provided by unpaid caregivers. Enter the name; a check if living in the Client's household; the approximate age; the relationship using the following codes; the tasks performed/support provided; and when the tasks will be performed.

Relationship Codes: 1 =Spouse 2=Son 3=Son-In-Law 4=Daughter 5=Daughter-In-Law 6 = Brother 7=Sister 8=Grandson 9=Granddaughter 10=Other Relative 11 =Friend 12 = Neighbor 13=Volunteer Group

Name		Age	Rel	Tasks Performed /Support Provided	When?

E. 24 HOUR COVERAGE

If the Assessment shows 24 hour coverage is needed, use this calendar to show coverage plans, including paid and unpaid caregivers. Write the hours covered each day beginning after midnight and who is covering (e.g., "12 - 8 am - Sam Jones").

	Time Covered / Name of Person Covering
Sunday	
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	

CAP PLAN OF CARE

CLIENT _____

F. REASON FOR REVISION

G. CLIENT CHOICE STATEMENT

The following must be reviewed and signed by the Client before initial and continuing CAP participation is approved. It must also be signed when certain revisions are completed. If the Client is unable to sign, the Client's representative may sign in his/her behalf. If the Client signs by a mark, it must be witnessed by someone other than the case manager. If the Client is not competent to make this choice, his or her representative must do so.

CLIENT STATEMENT

I understand that I have the choice of seeking nursing facility care instead of participating in the Community Alternatives Program. I choose to participate in the Commurnity Alternatives Program. I understand that I will get the services shown in the Plan of Care, and that these services may be changed as needed. I have been informed of my right to appeal the denial of participation in the Community Alternatives Program as well as the right to appeal any change in or denial of services provided through the Community Alternatives Program.

CLIENT'S SIGNATURE _____ DATE_____ WITNESS'S SIGNATURE FOR MARK _____ DATE _____

REPRESENTATIVE'S SIGNATURE_____ DATE_____ WITNESS'S SIGNATURE FOR MARK _____ DATE _____

H. AGREEMENTS

The following persons have reviewed the Plan of Care and agree to participate in the Plan.

Client's Physician _____ SIGNATURE _____ DATE

Case Manager _____ SIGNATURE _____ DATE

_____ RELATIONSHIP _____ SIGNATURE _____ DATE

_____ RELATIONSHIP _____ SIGNATURE _____ DATE

I.. LOCAL APPROVAL

PLAN APPROVAL ON _____ BY (SIGNATURE) _____

TITLE_____